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Bed Capacity at Riverview Psychiatric Center — RPC Referral Data is Unreliable; Other Factors Should Be Considered Before Deciding Whether to Expand, 2006

Maine State Legislature

Office of Program Evaluation and Government Accountability

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RAPID
RESPONSE
REVIEW

FINAL
REPORT



Bed Capacity at Riverview Psychiatric Center — RPC Referral Data is Unreliable; Other Factors Should Be Considered Before Deciding Whether to Expand

Report No. RR-RBC-06

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

April
2006

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ABOUT OPEGA & THE GOVERNMENT OVERSIGHT COMMITTEE

The Office of Program Evaluation and Government Accountability (OPEGA) was created by statute in 2003 to assist the Legislature in its oversight role by providing independent reviews of the agencies and programs of State Government. The Office began operation in January 2005. Oversight is an essential function because legislators need to know if current laws and appropriations are achieving intended results.

Although the Maine Legislature has always conducted budget reviews and legislative studies, until OPEGA, the Legislature had no independent staff unit with sufficient resources and authority to evaluate the efficiency and effectiveness of Maine government. The joint legislative Government Oversight Committee (GOC) was established as a bipartisan committee to oversee OPEGA's activities.

OPEGA's reviews are performed at the direction of the Government Oversight Committee. Legislators, committees, or members of the public should make their requests for reviews to the Chairpersons or any other member of the Committee.

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Bed Capacity at Riverview Psychiatric Center — RPC Referral Data is Unreliable; Other Factors Should Be Considered Before Deciding Whether to Expand

Purpose

The Maine State Legislature's Office of Program Evaluation and Government Accountability (OPEGA) conducted a rapid response review of data collected by Riverview Psychiatric Center (RPC) and reported to the Riverview Bed Review Committee (BRC). OPEGA conducted the review at the direction of the joint legislative Government Oversight Committee, and generally in accordance with M.R.S.A. Title 3, Chapter 37, §991-997 and the Government Auditing Standards set forth by the United States Government Accountability Office (GAO).

This rapid response review sought to determine:

- whether the conclusions being drawn from data collected at RPC, and analyzed by the BRC, are valid; and
- whether there is any other useful information that further analysis of the collected data could provide.

To supplement this rapid response review, the Government Oversight Committee also asked OPEGA to identify what key issues legislators should be concerned with when considering whether the capacity of RPC is adequate. The Legislative Guide developed by OPEGA includes an overview of Maine's adult mental health care system and questions legislators may want to ask as they consider whether to expand RPC.

Methods

In conducting this review, OPEGA:

- interviewed members of the BRC;
- reviewed a sample of monthly reports presented to the BRC;
- reviewed BRC meeting minutes for the period 10/03-12/05;
- reviewed the 2003 agreement specifying the data to be reported;
- analyzed the data collection and presentation;
- interviewed RPC staff responsible for collecting and reporting the data; and
- reviewed state reports on the mental health system and national trends.

Background

In July 2004, the State opened Riverview Psychiatric Center (RPC), which replaced the Augusta Mental Health Institute (AMHI). RPC is operated by the Department of Health and Human Services (DHHS). Bed capacity at RPC was based on a needs assessment completed in 2000. The needs assessment determined that 92 beds, 44 forensic and 48 civil, would be sufficient to meet present and future needs assuming projected improvements in the State's overall community mental health system were made.

Concerns about the adequacy of RPC's capacity and the sufficiency of community resources predate the Center's construction and continue today. These concerns are supported by the State's continued inability to fully comply with the AMHI Consent Decree, particularly with regard to community resources. The October 2005 Progress Report issued by Court Master, Judge Daniel E. Wathen, noted the need for improved continuity of care, housing resources, and residential services. A report issued in July 2005, Peer Review Visit for the National Technical Assistance Center for State Mental Health, noted that while Maine's system has not completely fulfilled its mission, it is "*steadily evolving and being transformed in positive and innovative ways.*" However, the report also noted that "...*Maine's system of mental health care has evolved in such a way that state hospital and community mental health service providers now tend to operate independent of one another, rather than as full partners in the continuum of care.*"

On April 9, 2003 an agreement was made between DHHS, the Maine Psychiatric Association, the Citizens Advisory Group, the National Alliance on Mental Illness (NAMI) Maine, the Maine Osteopathic Association, the Maine Medical Association, and the American College of Emergency Physicians ME. The agreement established the BRC and required data collection to determine the percentage of appropriate patients being denied admission to RPC. DHHS was required to present a plan to meet the needs of patients being denied admission to RPC if the percentage denied exceeded 30% for two consecutive quarters.

RPC has provided the Bed Review Committee with monthly reports of civil admissions and referrals since opening in July 2004. An excerpt of the referral data reported to the Bed Review Committee is below.

Month	Referrals admitted	Total inquiries of available beds	Referrals denied/does not meet criteria	Referrals denied/lack of capacity	Referrals denied/lack of capability
Sept. 05	22	81	0	35	0

The BRC submitted its final report and data analysis to the HHS Committee on January 11, 2006. Based on RPC's data, the BRC determined that on average 46% of appropriate civil referrals were denied admission due to lack of capacity in FY05. Among other things, the BRC recommended designing a third wing at RPC. DHHS disagreed with that recommendation.

Conclusions

No Valid Conclusions Can be Drawn From the Data Collected

The data collection process at Riverview was very uncontrolled, and resulted in data that was incomplete and inaccurate. Specific problems noted with the data collection process include:

- Data on faxed referrals was not collected although RPC receives many referrals via fax.
- Most data was collected manually by 7-8 different people, and there was no checklist or protocol to ensure that all data collectors followed the same process.
- Identifying information was not gathered for all referrals included in the data, therefore the unduplicated number of referrals cannot be determined.
- Appropriate referrals put on a waiting list for admission were not included in reported data until they were admitted, which may have been months later or not at all.

- The data collection process was not supervised nor were resources allocated to ensure the process was sound.

Since the data collection process lacked adequate controls, there is significant risk that counts reported in various data categories were over or understated each month.

Additionally, the presentation of data to the BRC was inaccurate and misleading. Specific concerns noted with the presentation include:

- The figures reported in the data categories did not always represent comparable events within the same time period. Consequently, these figures cannot be used to calculate reliable, meaningful totals or other statistics. For instance, the category for “referrals admitted” includes all patients admitted during the month with no regard for when the patient was originally referred (the patient’s initial referral call may have been received months earlier). This means that the categories for “referral admitted” and “referral denied/capacity” cannot be added together to find the total number of admissible referrals in a given month.
- The definitions for each data category did not accurately describe the data presented. For example, the definition for the “total inquiries of available beds” category was *“Call is made for a referral, but not all community options/alternatives have been explored. We recommend exploring alternatives. This is not considered a referral, but an inquiry.”* However, the figures reported in this category include all referral calls received, not just those where community options had not been fully explored.

The data collection and presentation weaknesses make it impossible to determine with any certainty how many appropriate individuals, or what percent of referrals, are being denied admittance to RPC due to lack of capacity. Although RPC is, and has been, turning away patients due to lack of capacity since opening, the magnitude of this condition is uncertain. OPEGA intended to review the original referral records to see if it was possible to develop a more accurate count. The records, however, have not been retained.

Analysis of Additional Data Could Not Be Performed

As noted above, original referral records supporting data reported to the BRC were not retained. In addition, the data specified in the 2003 agreement, which could have proved informative, was not the data provided to the BRC. The 2003 agreement stipulated that RPC collect and report:

- on patients experiencing long waits in emergency rooms before being admitted to a hospital; and
- specific data on referrals including date and time of referral, referring facility, response to the request for transfer, reason for response, and resulting placement of the patient.

This data was to be reported quarterly to the HHS Joint Standing Committee and made available to the public. Collection of the data would have required the cooperation of several community service providers represented on the BRC, including hospital emergency departments. Since no additional data was available, OPEGA could not perform further analysis to provide more helpful information regarding bed capacity at RPC.

Other Factors Must be Considered

The question of whether or not to expand capacity at RPC can not be answered without considering the rest of Maine’s mental health system. This system is dependent on cooperative

relationships between government, private sector businesses and non-profit organizations. All parties need to be in agreement about their respective roles, responsibilities, and expectations.

Current bed capacity is based on an assumption that the system offers enough services of varying types, including housing, to meet existing need. Some assert that demand for State in-patient psychiatric beds would decrease if the current system was functioning more effectively. Others contend more beds are needed because the community service system is not fully developed and is not likely to be.

Any service gaps and bottlenecks existing in this system would impact demand for beds at RPC and be indicators of broader system deficiencies. Stakeholders OPEGA spoke with identified several indicators and suggested collecting and analyzing data on them to improve service delivery and the overall system. Some of the service gaps and bottlenecks mentioned include:

- Patients being referred to RPC that could be treated more appropriately using other community services, such as crisis stabilization beds;
- Patients experiencing long waits in emergency rooms before being admitted to a hospital bed;
- Length of stay for patients who remain at RPC after being cleared for discharge has doubled in the last year; and
- Small group of people who continually cycle through a variety of mental health services, including RPC, and absorb significant system resources.

OPEGA understands that DHHS, as part of its ongoing effort to comply with the AMHI consent decree and in order to make other system improvements, has developed a number of performance indicators and begun collecting associated data. The Acting Commissioner of DHHS believes this data will help identify where true system deficiencies exist so that actions to address them can be taken.

Adding capacity to one part of an interrelated system without addressing root causes of other system deficiencies may temporarily ease pressure on that part, but the larger problems will remain. Consequently, the Legislature needs to consider all the components of the mental health system as the discussion about RPC proceeds. The Legislative Guide prepared by OPEGA, and submitted to the GOC under separate cover, expands upon a variety of factors impacting these components.

Recommendation

Design Future Mental Health Service Studies to Ensure Collection of Meaningful, Reliable Data

Future studies related to mental health services should clearly specify the purpose of the study, the question(s) being asked and how the data to be collected will answer it. Each study should be carefully designed and overseen so that data collection processes are controlled and the data collected is valid and can be relied upon to inform policy decisions and improve Maine's mental health system.

Department Response

In accordance with Title 3, Chapter 37, §996, the Department of Health and Human Services was provided with an opportunity to submit comments on the draft report. The Department's response dated March 27, 2006 is attached.

Acknowledgements

OPEGA would like to thank the members of the RPC Bed Review Committee and staff at DHHS and RPC who shared their time and expertise during this review. Their cooperation was appreciated.

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John Elias Baldacci
Governor

Maine Department of Health and Human Services

221 State Street
State House Station 11
Augusta, ME 04333-0011

March 27, 2006

Brenda M. Harvey
Acting Commissioner

*Beth Ashcroft, Director
OPEGA
82 State House Station
Augusta, ME 04333-1901*

Dear Beth:

Please find the departments response to the OPEGA Report given to the Government Oversight Committee dated February, 2006.

In April 2003, in response to LD 480, a Bed Review Committee (BRC), was established to address concerns raised by the community regarding the proposed size (92 inpatient beds) of the yet to be constructed Riverview Psychiatric Center, and its ability to handle the perceived demand for in-patient psychiatric care. The BRC set out a data collection process to routinely capture information to help them determine if the bed capacity of Riverview was adequate. The primary indicator to be collected was the percentage of appropriate patients referred to Riverview and then denied admission to RPC as a result of capacity.

Discussions by BDS officials with other in-patient hospitals to obtain this information raised an important challenge to being able to collect this data. Specifically, protections of information within the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA) law. There are three parts to this act, but the one most affecting this data collection effort involved the **PRIVACY** rule. This rule defines how covered entities handle protected health information and confidentiality. Riverview, as a State psychiatric facility, already follows very strict State and Federal confidentiality laws covering both mental health and substance abuse. The HIPAA privacy rule regulation extended additional coverage specifically around: Notice of Privacy Practices, Consent to authorizations, *Transfer of protected health information*, access, security, safeguards, data tracking and management and complaints/investigations. The HIPAA privacy rule is the only rule of HIPAA that is enforced by the office of Civil Rights, with the authority to impose up to \$250,000.00 in fines and possible imprisonment for up to ten years for a breach of confidentiality.

Almost all of the information being collected by the Department for the BRC was in some fashion protected information. As a result, referral parties were not able to share specific information with Riverview, unless it was thought Riverview would be entering into a care relationship with the client. As a result of discussions with the BRC, RPC adjusted the report and provided the committee as much information as it could provide. Much of this data was "soft", in that it represented informal assumptions on the nature and intent of "inquiries/referrals" when specifics were not directly shared. As an example, a number of calls are simply identified by the referring agency, as, male voluntary patient and the agency is making an initial inquiry as

Beth Ashcroft, Director

March 24, 2006

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to an available bed. Because of the HIPAA privacy rule, the referring agency can provide only that very limited information above, unless RPC had an available bed and accepts the patient for transfer. Only until the acceptance occurs can more useful data be collected. Although attempts were made to request specialized identifier numbers by referral sources, it is important to realize Riverview has no supervisory relationship with those sources and could not enforce cooperation with such strategies. This situation exists on at least 40% of the calls and has a significant affect in each month's statistics. Therefore, there was discussion within the committee as to how these referrals should be counted. As the purpose was to assess the frequency of the intent to utilize Riverview Psychiatric Center as a resource, the soft data was accepted in good faith as the best available information to assist the committee in that charge.

During this reporting period, no referral remained on a waiting list longer than 20 days. Because the data was presented to the BRC on a monthly basis, in a continuous report format (on-going data since July of 04) and the data had limited additional value to Riverview, the data was not maintained post the completion of the report.

After continued discussions with the committee, RPC has implemented a series of improvements to the collection and dissemination of information. These improvements are:

RECOMMENDATION:

1. The Admission's Coordinator will implement a daily data collection log to capture and then report the following data elements. Each regular work day, the Admission coordinator shall review the log and ensure all categories have been addressed to the best extent possible. The Admissions Coordinator shall ensure all persons collecting data shall be oriented and trained on this process.
 - a. Date/time of call
 - b. Patient name (if given)
 - c. Civil (voluntary or Involuntary)
 - d. Forensic (legal status)
 - e. County (patient residence)
 - f. Region (1, 2 or 3)
 - g. Meets Criteria (for admission)
 - h. Does not meet Criteria (for admission)
 - i. Information faxed to RPC
 - j. Information given by phone to RPC
 - k. Crisis worker and or agency
 - l. Patient admitted and what unit
 - m. Patient not admitted
 - n. Patient placed on the waiting list
 - o. Patient scheduled for admission

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The log will be manually filled out and then placed on an excel spreadsheet. N/A will be identified for protected data not able to be recorded. The information collected will be presented to the Superintendent every month prior to further distribution. The hand written logs will be maintained for a period of 3 years or according to state law.

DHHS will be supplying additional information to OPEGA and the Legislative Committee under separate cover.

Sincerely,

A handwritten signature in cursive script that reads "Brenda Harvey".

Brenda M. Harvey
Acting Commissioner